TRICARE
Central Region

Referral Management 2002: Lessons Learned

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INTRODUCTION

- 2 YEAR IMPROVEMENT PROCESS
- Review joint partnership of DoD and TriWest in harnessing technological improvements for clinical opportunities
- Program – Electronic Referral Management
- Process – Paperless, automatic
- Tools - Many
- Lessons - Many

Mythology of RM

- 6 Prohibitive – Labor intensive
- 5 Cannot dictate practice patterns
- 4 Not applicable – have no specialists
- 3 CPGs have replaced UR – Outdated
- 2 SIDR/SADR data is reliable –tells accurate story of needs/utilization
- 1 We are not accountable for network costs

Starting Point: Foundation

- MCSC Loopholes
- OSD/HA Mandate
- Population Health Plan
- JCAHO – Continuum of Care
- HIPAA – TMA R & A System
- CHCS Improvements
- McKesson – InterQual and Milliman

Starting Point: RM Real Picture

- Poor return of clinical results – 50% with work
- Provider dissatisfaction / FRUSTRATION!
- Inability to optimize primary care
- Decreased access to specialty care – to network
- Pressure to increase productivity
- Fragmented care – missed care management
- Delayed care – lack of documentation
- Manual labor – very intensive
- Bottom Line: Dissatisfied customers and administrators – Increased costs

Opportunity Statement Oct 1999

- An opportunity exists to improve the management of referrals by capturing recent technological advances. The current process is ineffective and expensive, and fragmented. Electronic referral management provides more appropriate/timely care to beneficiaries at less cost, provides the continuum to reach optimization and facilitates care management programs.

Goals of Electronic RM

- Greater return of clinical information
- Informed Staff – patients and criteria
- Fewer **referrals** to network, more **consulting**
- PCM optimization
- Specialty optimization

- Timely referral to care management
- Happy customers, Happy Administrators
- Reduced Network Cost

PAT: Joint TriWest, EACH, AFA, LAO

- TriWest – Administrative appointing
- MTF Clinical – MD, TSD and UM – AFA and EACH
- Administrative Care Lines
- IM/IT essential
- LA Contracting and MTF COTRs
- Physician Champion

Phases of Improvement

- I. Centralize Opportunity
  - Close loop with Referral Tracking
- II. MTF Clinic Review
- III. Network Review
  - Administrative Review
  - Clinical UM – Increased consulting, decreased referrals = optimization

  IV. Electronic Resulting – clinically vs administratively

Phase I: Centralize Opportunity

- All electronic consults – Consult is a RX
- Standardize SF 513: critical elements:
  - Name
  - Referring clinic and provider
  - Diagnosis
  - Specialty Needed
  - Reason for Referral with clinical info
  - Priority
- These fields are all HIPAA requirements of 278 transaction

Phase I: Centralize Opportunity

- Secrets of Success
  - Centralize Referral Tracking - Clerical
  - Eval vs Eval and Treat
  - POC Address and FAX central on CHCS consult – Sent with network auth by contractor
  - Capture ALL Consults in Database :
    - PCM Mail, TSC distribution, etc.
  - Quarterly audit to validate data

Phase I: Centralize Opportunity

- Tricks of the Trade
  - Data base with minimal fields (atch)
  - CHCS Adhoc Report (atch)
- Process: Daily, all network consults appear in database from CHCS transfer
- FAX from Contractor (TriWest AND MBC) ALL consults from network on enrollees

Phase I: Centralize Opportunity

- Close Consult in CHCS by referral center staff
  - When results are returned
    - Review
    - Patient
    - Results received (#23, exact steps – see atch)
    - Hand sign results – Referral stamp
    - Forward to PCM
    - Forward to Medical Records
  - If providers get results without Referral Center mark,

results must go to referral center!

Phase I – Holding the Gain on Clinical Return

- Trended delinquent providers/groups to TriWest/MBC
- Added as referral surveillance item
- CAEC Standard Agenda Item
- Resources: 1 FTE
- 25.5 K referrals/year with 98% return of clinical information

Phase II – Clinical Review

- ALL Clinics using CHCS
- All Clinics in CHCS must review –
  - every business day – maybe twice/day
  - 24 hour limit
- Primary and alternate reviewer
- Clinical POC or Clinical oversight
  - Scope, capacity AND access by ben cat

Phase II: MTF First Right of Refusal

- Disposition:
  - BOOK TO MTF – clinic or TriWest books
  - INFO NEEDED – unable to determine – sends CHCS email to provider for info
  - REFER TO SUBSPECIALTY – Another Clinic – or reviewing “clinic”
  - NO APPT NEEDED (only duplicate consults; change in health status no longer warrents, etc)

First Phase II: MTF Right of Refusal

- Key Success Factors:
  - Clean Pick List – Clinic-reviewer 100% match
  - Ben Cat –
    - AD, PRIME,
    - TRICARE Plus, Space A
  - Sufficient Clinical Info – Medical Necessity
  - Appropriate Clinic – within scope
  - Scope PLUS access considered – Book to MTF means just that

Phase III: Network Review

- Network Clinic
- Administrative Review
- Review Factors
  - specialty, clinical review, ben cat, priority
- Disposition:
  - MTF specialty: Refer to subspecialty
  - Non- MTF Specialty: Defer to Network

Phase III: Network Review

- Key Success Factors
- All dates
- Weekly Sweep of clinics
- POC for review accountability plus alternate
- Provider education

Active Duty Consult Review for Supplemental Health Care Funding

- Process – MCSC needs written Commander's Designee for Approval Authority – cannot be delegated to contractor
- CHCS Electronic Steps to Obtain review, approval – via Email

Phase III: Network Review

- **Clinical Review**
  - Above Plus Medical Necessity and Recapture Potential
  - A better alternative for Phase III admin review, not an addition
  - Use of McKesson InterQual (and Milliman Care Guidelines for Pediatric Specialty Referrals) – This will be automated in TMA's HIPAA compliant R & A system
  - Recommend CPUR for RN reviewer

Phase III: Clinical Network Review

- Examples
  - Appropriate Specialty
  - Optimize Primary Care
  - Care Management
    - ActiveDuty Fitness for Duty
    - Disease Management
    - Health Care Coordination
    - Case Management

Phase IV: Electronic Clinical Resulting

DoD Examples in CTS

1. Internal MTF consults type brief statement of treatment with transcription back-up hardcopy of full report
2. Transcription inputs entire report to CHCS – to provider to verify
3. Referral Center scanning network results in CHCS

Electronic record enhances provider access to results and measurement of return time

– Supports MHS Optimization

Electronic RM: Outcomes

- Referral Patterns
  - Eg., Ophthalmology
- Clinic Dispositions
  - MTF
  - Network
- Lack of Documentation
- Care Management Access

Electronic RM Pitfalls

- No executive support /resources
- No Provider Champion
- Failure to Clean Pick List
- Bean Count Mentality – RVUs better
- Lack of Documentation - # 1 MTF issue
- Routed to wrong Clinic
- No Rx – beneficiary request; telcon
- ASAP/Urgent Consults provider to provider

Electronic RM Pitfalls (cont)

- Eligibility
- Skipped Dates of Clinical Review
  - Network clinic reviews Date vs ALL dates
- Consult does not print out – safety for network clinics - Close the Loop
  - Bene is told to call TSC for no response in 10 days on routine consult

Electronic RM: Hold the Gain

- Orientation and Marketing a Must
- Keep Pick List current
- Feedback to Prostaff; Exec Committee
- Access to Criteria; informed providers
- Standard Operating Procedures, OIs,
- MOUs

Electronic RM

- Limitations:
  - At present, does not capture referrals from Network – Needs to be loaded – already done in DoD – Concern regarding consult archiving
  - Not failsafe – ensure quality checks
  - Does not capture any referral or consult not sent electronically-already done in DoD
  - Unable to send results back electronically

  TMA IM/IT working this thru HIPAA compliant R & A electronic system

Electronic RM

- Summary of Lessons Learned
  - Very efficient system-supported method to ensure appropriateness and continuity of care if executive team supports; Supports HIPAA 278
  - Key tool to MTF optimization and survival
  - Not resource added but re-engineered
  - UM clinical involvement takes opportunity to new level